



DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Division of Survey and Certification

May 9, 2012

Rod Barton, CEO
Cassia Regional Medical Center
1501 Hiland Avenue POB 489
Burley, ID 83318



CMS Certification Number: 13-1346

Re: Plan of Correction received

Dear Mr. Barton:

The Centers for Medicare and Medicaid Services (CMS) is in receipt of Cassia Regional Medical Center's voluntarily-submitted plan of correction in response to the complaint survey conducted on April 19, 2012, by the Idaho Bureau of Facility Standards (State survey agency). CMS appreciates the time and effort by you and your staff in developing and implementing the plan of correction.

If you have any questions, please contact me at (206) 615-2090/email linda.bedker@cms.hhs.gov or CAPT Dorothy Stephens at (206) 615- 2648/email dorothy.stephens@cms.hhs.gov .

Sincerely,

Linda Bedker, RN, MN, MPH
Nurse Consultant
Survey, Certification and Enforcement Branch

cc: Idaho Bureau of Facility Standards



DEPARTMENT OF HEALTH & HUMAN SERVICES
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**IMPORTANT NOTICE – CORRECTED CONDITION
PLEASE READ CAREFULLY**

April 24, 2012

Rod Barton, CEO
Cassia Regional Medical Center
1501 Hiland Avenue (Box 489)
Burley, ID 83318

CMS Certification Number: 13-1346

**Re: Complaint survey 04/19/2012 with Conditions of Participation (CoP) not met
Deemed status removed and placed under State survey jurisdiction
Full health and life safety code survey to be conducted**

Dear Mr. Barton:

The Idaho Bureau of Facility Standards (State agency) completed a complaint investigation authorized by the Centers for Medicare & Medicaid Services (CMS) on April 19, 2012. Based on a review of the deficiencies identified during this investigation, CMS has determined that Cassia Regional Medical Center **is not in substantial compliance** with the Medicare hospital Condition of Participation (CoP) – **Emergency Services** (42 Code of Federal Regulations (CFR) § 485.618). To participate as a provider of services in the Medicare and Medicaid Programs, a hospital must meet all of the CoPs established by the Secretary of Health and Human Services

Further, in accordance with Section 1865 of the Social Security Act (The Act) and pursuant regulations provide that a hospital accredited by The Joint Commission will be “deemed” to meet all Medicare health and safety requirements with the exception of those relating to utilization review. Section 1864 of The Act authorizes the Secretary of Health and Human Services to conduct a survey of an accredited hospital participating in Medicare if there is a substantial allegation of a serious deficiency which would, if found to be present, adversely affect the health and safety of patients.

As a result of the April 19, 2012, complaint survey findings, CMS is required to provide timely notification of the accrediting body and to place the hospital under Medicare State agency survey jurisdiction. State agency survey jurisdiction remains in place until the hospital is in compliance with all Conditions of Participation.

The deficiencies cited in the April 19, 2012 survey limit the capacity of Cassia Regional Medical Center to furnish services of an adequate level and/or quality. The deficiencies that led to CMS' decision are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). It is not a requirement to submit a plan of correction. However, under federal disclosure rules, the findings of the inspection, including the plan of correction submitted by the facility, become publicly disclosable within 90 days of completion.

If you choose to submit plans for correcting the deficiencies at your facility, you must do so within 10 calendar days of receipt of this letter. An acceptable plan of correction contains the following elements:

- The plan for correcting each specific deficiency cited;
- The plan should address improving the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

Each deficiency should be corrected as soon as possible. Additionally, please sign and date page one where indicated prior to returning the CMS-2567 to our office. Please send the completed plan of correction to the address below, with a copy to the State agency:

CMS – Survey and Certification
Attention: Dorothy Stephens
2201 Sixth Avenue, RX-48
Seattle, WA 98121
Fax: (206) 615-2088

Additionally, in accordance with § 1865(b) of The Act, the Idaho Bureau of Facility Standards, will conduct a full unannounced health and life safety code survey of your hospital to assess compliance with all the Medicare Conditions of Participation, within the next 60 days.

The recommendation that Cassia Regional Medical Center submit a plan to correct its Medicare deficiencies does not affect its accreditation, its Medicare payments, or its current status as a participating provider of hospital services in the Medicare program. When Cassia Regional Medical Center has been found to meet all the Medicare Conditions of Participation for hospitals, the State agency will discontinue its survey jurisdiction.

Page 3 – Mr. Barton

Under CMS regulations 42 CFR § 498.3(d), this notice of findings is an administrative action, not an initial determination by the Secretary, and therefore formal reconsideration and hearing procedures do not apply.

Copies of this letter are being provided to the State agency and The Joint Commission. You can also pursue any concerns you may have with The Joint Commission at any time.

If you have any questions, please contact me at (206) 615-2648 or by email at Dorothy.stephens@cms.hhs.gov.

Sincerely,

Dorothy Stephens
Health Insurance Specialist
Survey, Certification and Enforcement Branch

Enclosure

cc: Debra Ransom, Idaho Bureau of Facility Standards
The Joint Commission



Intermountain
Cassia Regional
Medical Center

1501 Highland Avenue
Burley, ID 83318
208.678.4444

RECEIVED

MAY 07 2012

FACILITY STANDARDS

May 4, 2012

Idaho Department of Health and Welfare
Bureau of Facility Standards
Attn: Gary Guiles
PO Box 83720
Boise, Idaho 83720-0009

RE: State Survey 4/19/2012

Gary,

Enclosed you will find a copy of the correction action plan for Cassia Regional Medical Center. Please feel free to contact me if you have any questions or concerns about the information. An original copy has been submitted to the Regional Office in Seattle as directed.


A handwritten signature in blue ink that reads "Jeanette Wheeler".

Jeanette Wheeler

Cassia Regional Medical Center
1501 Hiland Ave
Burley, Idaho 83318
208-677-6585
208-431-0474

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2012
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131326 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 04/19/2012 |
| NAME OF PROVIDER OR SUPPLIER CASSIA REGIONAL MEDICAL CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1501 HILAND AVENUE BURLEY, ID 83318 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X6) COMPLETION DATE |
| C 000 | INITIAL COMMENTS The following deficiency was cited during the complaint survey of your CAH. Surveyors conducting the investigation included: Susan Costa, Rn, HFS, Team Leader Gary Guiles, RN, HFS, BG = Blood Glucose DM = Diabetes Mellitus ED = Emergency Department EDR = Emergency Department Record IV = intravenous LIP = licensed independent practitioner LWOT = Leave Without Treatment 485.618 EMERGENCY SERVICES | C 000 |  Response for C200 and C274 contains related elements for triage, patient monitoring between triage and physician assessment and medical record documentation: | |
| C 200 | The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients. This CONDITION is not met as evidenced by: Based on staff interview and review of medical records and policies, it was determined the CAH failed to ensure emergency care was provided sufficient to meet the needs of 8 of 23 patients (#4, #7, #15, #16, #18, #19, #22, and #23) who presented to the ER seeking care and whose records were reviewed. This resulted in the inability of the CAH to triage patients and to ensure they were monitored while waiting for examination by a physician. Findings include: 1. The hospital had not provided specific direction to staff for triaging patients in the ED and monitoring them while they waited to be | C 200 | To supplement existing Emergency Department Triage Policy previously submitted, a facility level procedure titled: <u>Cassia Regional Medical Center (CRMC) Emergency Department Triage Procedure</u> has been updated and is under review for final approval and implementation. This document outlines the steps that are to be taken by the Emergency Department (ED) staff in triaging a patient in the ED. This document will be reviewed by ED Quality Committee scheduled for May 14 th , submitted for review and approval to Medical Executive Committee May 16 th and then submitted to the Governing Board for final approval May 23, 2012. A triage workshop is scheduled for the ED staff May 24 th for education and final implementation. | 5/23/2012 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Administrator

5-4-2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other

safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| C 200 | <p>Continued From page 1 examined by a physician. This led to a lack of care provided to patients.</p> <p>a. The policy "Emergency Department Triage Policy," dated January, 2009, defined triage as "The sorting out and classification of patients or casualties to determine priority of need and proper place of treatment." The policy stated "Each Emergency Department will determine: 1.2 Who initially assesses the patient. 1.2.1 Where this initial assessment takes place. 1.2.2 Training required of those performing the initial assessment. 1.3 Components of the initial assessment to be performed based upon the patient's chief complaint and/or reason for coming to the ED. 1.3.1 Training required of the staff performing the assessment. 1.4 The minimum criteria that comprises the initial nursing triage/assessment of the patient. 1.4.1 Components of the nursing triage/assessment to be performed based upon the patient's chief complaint and/or reason for coming to the ED. 1.4.2 Training required of the staff performing the assessment." The policy stated the ED would use a 5 level triage classification system including resuscitative, emergent, urgent, semi-urgent, and non-urgent. The policy did not specifically state who could perform a triage assessment or the training required to do so. The policy did not specifically define a minimum triage assessment, for example, whether vital signs were required or not. The policy did not define where the triage assessment should take place. In addition, the policy did not specify how patients would be monitored after they were triaged and while they were waiting to be examined by a physician.</p> <p>The Director of Quality and Risk Management</p> | C 200 | <p><u>Continued from previous page</u> C200: DRAFT Triage Procedure abstract:</p> <p>The nurse or registration staff will acknowledge patients entering through the ED entrance. If an RN is not present in triage, the registration clerk will call for the RN and notify the nurse that a patient needs triage. Triage is completed by the following Emergency Severity Index (ESI) process:</p> <p>Decision Point A: The Triage Nurse will determine if the patient needs Life-Saving Interventions. Patients fitting this classification, ESI Level I (resuscitative) will be taken directly to a room and immediate physician intervention requested. Level I (resuscitative) Classification: Requires immediate life-saving intervention.</p> <p>Decision Point B: When Level II (emergent) condition is identified, the patient is taken directly to a room and immediate physician intervention requested. Level II (emergent) Classification: High risk situations, new onset confusion, lethargy or disorientation, severe pain/distress, patients requiring two or more resources.</p> <p>Decision Point C: When patients not meeting level I (resuscitative) or level II (emergent) classification, the nurse should utilize resource intensity determination to assign acuity. Level I (resuscitative) and Level II (emergent) Classification: Patients requiring two or more resources with vital signs not in danger zone. Level III (urgent) and Level IV (semi-urgent) Classification: Patients requiring I resource only. Level V (non-emergent) Classification: Patients requiring no resources.</p> <p>Decision Point D: Nursing to assign higher level of triage based on current vital signs. Patient with vital signs in the danger zone are reclassified as Level I, Level II or Level III and assigned a bed immediately. Danger zone vital signs defined as: When pulse, respiratory rate, oxygen saturation, and temperate (under age 3) are outside of the normal range for the patient's age.</p> | | |

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| C 200 | <p>Continued From page 2</p> <p>was interviewed 4/18/12 beginning at 11:05 AM. She stated the hospital did not have specific policies defining the triage process and the monitoring of patients. She stated the hospital had developed specific policies in the past but these policies had been rescinded and replaced by the current policy. She also confirmed a policy regarding the monitoring of patients while waiting for examination had not been developed.</p> <p>b. Patient #15 was a 16 year old male who came to the ED on 3/31/12. The time of registration entered into Patient #15's record was 5:39 PM. The triage RN assigned Patient #15 acuity of "Urgent" at 5:32 PM, and noted "shot with BB hit inside L (left) eye/nose (with) pain." The "PRIMARY ASSESSMENT" by the RN was timed at 6:43 PM, which was 1 hour, 10 minutes after the triage. It was not clear how the classification of "Urgent" was determined, or why the care for Patient #15 was delayed for more than 1 hour.</p> <p>The ED Manager was interviewed 4/18/12 beginning at 11:30 AM. She reviewed Patient #15's record and confirmed the times of triage as well as, the primary assessment. She was unable to determine why the primary assessment was delayed with acuity of "Urgent."</p> <p>c. Patient #19 was a 36 year old female who came to the ED on 3/29/12. The time of registration entered into Patient #19's record was 7:17 PM. The triage RN assigned Patient #19 acuity of "Semi-Urgent" at 7:10 PM, and noted "(patient) feels shaky -5 hrs. Hx (history) DM, BG (blood glucose) 218 today." The "PRIMARY ASSESSMENT" by the RN was timed at 7:40 PM, which was 30 minutes after the triage. It was not</p> | C 200 | <p><u>Continued from previous page:</u></p> <p>If beds are available, patients may be directly taken to the treatment area. All patients presenting will have a quick registration completed by the admission clerk. If two or more patients are waiting to be triaged, a quick triage will be performed to prioritize the patients. Full triage, including vital signs and patient height and weight, may be completed on all patients waiting for a treatment room assignment. Patients waiting to be taken to the treatment area will have a reassessment completed and documented as determined by RN clinical judgment. The reassessment will include a notation indicating the nurse saw the patient and any other interventions provided will also be documented on the triage assessment form. Any significant symptoms should be reassessed for change and the acuity category increased if necessary. Triage is a dynamic process; a patient's condition may improve or deteriorate during the wait for entry to the treatment area. Patients should have vital signs repeated at least every two hours or more frequently as determined by the RN based on ESI danger zone criteria.</p> <p>Obstetrical patients greater than 20 weeks with high risk OB/Delivery clinical features will be transferred to labor and delivery (L&D) for MSE unless: The medical condition precludes transfer (e.g., pregnant patients with either trauma or fever and respiratory symptoms should not be transferred to L&D), or The ED triage RN and L&D charge RN agree the patient should remain in the ED for MSE and management. ED physician will determine patient disposition. Obstetrical high risk clinical features include: vaginal bleeding or discharge, abdominal pain or cramping, lower backache, features of pre-eclampsia, hypertension, headache, visual disturbances, right upper quadrant pain, edema, fetal distress in a stable mother.</p> | | |

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| C 200 | <p>Continued From page 3</p> <p>clear how the classification of "Semi-Urgent" was determined, or why the care for Patient #19 was delayed 30 minutes.</p> <p>The ED Manager was interviewed 4/18/12 beginning at 11:45 AM. She reviewed Patient #19's record and confirmed the triage and primary assessment times. The ED Manager stated the practice of the RN was to evaluate each patient individually, and assign triage acuity. She was unable to state specific criteria for triage acuity and related activities.</p> <p>d. Patient #7's medical record documented a 31 year old female who presented to the ED on 4/12/12 at 8:53 AM. The EDR stated Patient #7's chief complaint was "migraine." The triage section of the EDR stated "Pt was seen in [physician office] & given Amlopidine [a blood pressure medication] & has been nauseated." The triage section of the EDR also stated her blood pressure was elevated. The "Triage Acuity" section stated Patient #7 was classified as "Semi-urgent." It was not clear how this classification was determined since no assessment or vital signs were documented.</p> <p>Patient #7's EDR contained a section labeled "PRIMARY ASSESSMENT" which documented an assessment by the RN beginning at 10:10 AM. It stated Patient #7 had vomited and her pain level was 7-8 of 10. A check indicated a neurological assessment was within defined limits, or normal. Her blood pressure was 158/126. (Medline Plus, a service of the National Institutes for Health, defined normal blood pressure as 120/80 or lower. It defined high blood pressure as 140/90 or above.)</p> | C 200 | <p><u>Continued from previous page:</u></p> <p>When the Emergency Department has reached its maximum bed capability/capacity, the facility surge plan will be initiated to use the consultation and/or waiting room for a triage area. Families and visitors will be moved from the waiting area to the CRMC Boardroom which is located next to the Emergency Department. In disaster mode, the Internal Medicine Clinic will be used as the E.D. overflow area for patients triaged as a 'Green' category. This is defined in the C.R.M.C. Emergency Operations Plan.</p> <p>ED Staff training Requirements: RN: Triage nurses will be trained on the policy/procedure of triage (in addition to Intermountain Clinical Practice Guidelines: ED Chief Complaint), EMT: Current state certification. Certified Nurse's Assistant (CNA) Vital sign training and training on severity of chief complaint Registrar: Training on severity of chief complaint.</p> | | |

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| C 200 | <p>Continued From page 4</p> <p>The EDR documented the physician examined Patient #7 beginning at 10:30 AM on 4/12/12. The "ED Physician/LIP Report," dated 4/12/12 at 12:36 PM, diagnosed Patient #7 with headache and "Hypertension, which could be related to each other." Patient #7 was treated with IV fluids, IV narcotic pain medication, and IV anti-nausea medication.</p> <p>Patient #7 was discharged home at 12:48 PM. Nursing notes stated her pain level had decreased to 2/10. Her blood pressure continued to be very high, however. The last documented blood pressure was dated 4/12/12 at 12:51 PM. It was 172/128.</p> <p>The RN who cared for Patient #7 was interviewed on 4/18/12 beginning at 8:05 AM. She reviewed the EDR. She stated Patient #7 had presented to the ED at 8:53 on 4/12/12. She stated she had come to the window in the reception area and talked with Patient #7. She stated Patient #7 complained of a headache and said her blood pressure was high. The RN stated Patient #7 had an appointment with her primary care physician off site at 9:15 AM but her headache was very painful so she came to the ED for treatment. The RN stated the ED was busy so Patient #7 was told it would be faster if she left and went to the appointment with her primary care physician. The RN stated Patient #7 left the ED and went to her physician appointment and returned later that morning. The RN confirmed this was not documented.</p> <p>The RN who cared for Patient #7 was asked about the triage level assigned to Patient #7. She</p> | C 200 | <p>C200:</p> <p>Education will be completed regarding triage and triage assessments. ED staff RN's, Certified Nurse Aides (CNA) will be educated on vital sign training and severity of chief complaint to assist the RN. Registrars will be trained on severity of chief complaint as part of the quick registration process. A computer based training module titled <i>Emergency Nursing Triage: The Triage Process: Part I and Part II</i> have been assigned to the ED RN staff with a completed date of May 16, 2012. These modules outline the steps of the triage process, how to obtain chief complaint, the triage quick-look assessment, various sensory assessments for completing the triage quick-look assessment, how to utilize history and physical findings and correlate the need for emergent or urgent care, communication techniques used to complete the history, identifying normal and abnormal vital signs, triage documentation and the importance of reassessment of the triaged patient.</p> <p>A triage skills workshop will be held May 24th and include review and implementation of <u>CRMC Emergency Triage Procedure</u> and hands on documentation of the triage assessment. Staff will also be presented with scenarios of patients presenting to the ED to determine appropriate assignment of ESI acuity level.</p> | <p>6/1/2012</p> <p>5/24/2012</p> |

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| C 200 | <p>Continued From page 5</p> <p>stated she did not assess Patient #7 except to speak with her briefly. She stated she did not take Patient #7's vital signs. No physical assessment was done prior to Patient #7 leaving the ED. The RN stated she completed some triage assessments without physically examining patient and without taking their vital signs. She stated patients were assigned a triage acuity level based only on a short conversation. She stated she was not aware of a hospital policy that defined triage assessments or listed a procedure for them.</p> <p>e. Patient #22's medical record documented a 30 year old female who presented to the ED on 3/15/12 complaining of left ear pain. The time of her arrival was not documented. A set of vital signs was documented at 10:32 PM on 3/15/12. These were within normal limits. Except for the vital signs, no contact with an RN was documented. No triage assessment was documented. No triage acuity level was assigned. No examination by a physician was documented. A form, "REJECTION OF TREATMENT/LEAVING AGAINST MEDICAL ADVICE," dated 3/15/12, was signed by Patient #22 and an RN. The time it was signed was not documented. An "ED Nurse Visit Note," dated 3/16/12 at 1:00 AM, stated Patient #22 left without treatment because the wait was too long. No other documentation was present to explain the course of events for Patient #22.</p> <p>The medical record for Patient #22 was reviewed with the ED Manager on 4/18/12 beginning at 11:40 AM. She confirmed a triage assessment was not documented. She stated she could not tell when Patient #22 presented to the ED. Since</p> | C 200 | <p>C200:</p> <p>Following training, from June 1st through August 1, 2012 concurrent review of 100% of ED visits will be conducted by the ED staff members for two months to ensure understanding of triage level assignment and documentation requirements. Medical records of patients seen in the ED each day will be reviewed prior to the end of the shift by the primary care nurse. A review worksheet will be completed to determine compliance with the areas of documentation: triage assessment and acuity assignment, Pain-assessment, pain intervention and reassessment, Medications ordered and given, vital signs and monitoring, physician orders for date and time notation, and interventions provided by nurse or ancillary departments (laboratory and x-ray). Compliance with areas of review will be calculated for each ED team member by the department manager and shared during monthly department meetings. Individual counseling will occur as needed. The ED manager or staff designee will perform random record review monthly through end of 2012 to determine continued compliance and then quarterly through 2013 to sustain improvements and then annually thereafter. Information will be reported to staff during team meetings and through monthly Quality Council reports.</p> | | 8/1/2012 and ongoing |

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| C 200 | <p>Continued From page 6</p> <p>Patient #22 was at the ED at least 2 hours and 28 minutes without documentation of an assessment, the ED Manager was asked about a policy for monitoring patients while they waited to be examined. She stated staff tried to check the waiting room every 15 to 30 minutes, She stated staff did not document this. She also stated a policy specifying how patients would be monitored had not been developed.</p> <p>f. Patient #23's medical record documented a 58 year old male who presented to the ED on 3/15/12 at 11:18 PM complaining of leg pain. No documentation was present to show Patient #23 was triaged or otherwise assessed by an RN. No examination by a physician was documented. A form, "REJECTION OF TREATMENT/LEAVING AGAINST MEDICAL ADVICE," dated 3/15/12, was signed by Patient #23 and an RN. The time it was signed was not documented. The form stated Patient #23 decided not to wait and went to another emergency room.</p> <p>An "ED Nurse Visit Note," dated 3/16/12 at 1:02 AM, stated Patient #23 left without treatment because the wait was too long.</p> <p>The medical record for Patient #23 was reviewed with the ED Manager on 4/18/12 beginning at 11:40 AM. She confirmed a triage assessment was not documented. She confirmed no documentation was present that Patient #23 was monitored during the 1 hour and 44 minutes while he waited to be seen.</p> <p>g. Patient #16 was a 6 year old female who came to the ED on 3/29/12. The time of registration entered into Patient#19's record was 5:30 PM.</p> | C 200 | | |

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| C 200 | <p>Continued From page 7</p> <p>The triage RN documented Patient #16 had complained of left wrist pain after falling off of a trampoline. Triage acuity for Patient #16 was not documented, and there was no triage time, although the arrival time on the EDR stated 3:30 PM and 6:20 PM.</p> <p>The "PRIMARY ASSESSMENT" by the RN was timed at 6:20 PM, and included a note as follows: "1600 (4:00 PM) - pt arrived @ 1500 (3:00 PM,) LWOT @ 1600- back at 1820 (6:20 PM) to be seen."</p> <p>It was unclear if Patient #16 had been initially triaged at 4:00 PM, or at 6:20 PM. The EDR did not contain further documentation of why Patient #16 left, or if there was an assessment of the patient condition before she left. The LWOT form was not in the patient record as the RN had documented in her note.</p> <p>h. Patient # 4 was a 31 year old male who came to the ED on 12/17/11. The time of registration entered into Patient #4's record was 11:27 AM. The RN documented triage at 11:25 AM, and stated Patient #4 had a past medical history of depression and had taken 15-25 pills of Paxil, an antidepressant. There was no triage acuity assigned.</p> <p>The "PRIMARY ASSESSMENT" by the RN was timed at 12:17 AM. The EDR contained documentation Patient #4 was placed on a monitor at 12:00 PM. The EDR did not indicate why the assessment and monitoring of Patient #4 had been delayed more than 30 minutes.</p> <p>In an interview on 4/17/12 at 5:07 PM, the ED</p> | C 200 | | | |

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| C 200 | <p>Continued From page 8 Manager reviewed Patient #4's medical record and was unable to determine why assessment and treatment of Patient #4 had been delayed.</p> <p>The hospital had not developed and implemented a system to triage and monitor ED patients.</p> <p>2. Diabetic patients were not monitored sufficiently to determine if therapeutic interventions were effective, and ensure documentation of physician notification. Examples are as follows:</p> <p>a. Patient #18 was a 46 year old male who was an insulin dependent diabetic. He came to the ED on 3/27/12 at 7:55 AM, and the triage note included: "pt. seen in ER on 3/23/12. Scrotum now black and swollen."</p> <p>The EDR for Patient #18 documented the following events:</p> <p>-8:10 AM vital signs were obtained. -8:38 AM blood was drawn for lab work -9:17 AM report of critical glucose level of 786 called to ED RN, (according to the American Diabetes Association, a diabetic with a blood sugar above 120 would be considered out of normal range.) -11:00 AM, Regular Insulin 10 units was ordered by the physician, -11:10 AM, Insulin was administered by the RN, -12:40 PM, blood sugar tested at bedside, result >600, too high for the bedside glucometer to determine level, -1:55 PM, Patient was transferred by helicopter to referral facility.</p> | C 200 | <p>The ED staff will be re-educated regarding the hypoglycemia /hyperglycemia Clinical Practice Guideline during the May 24th workshop. The guidelines indicate patient care management, including obtaining blood glucose sample via finger stick for blood sugar baseline and ongoing evaluation. These guidelines include pre and post treatment assessment, reportable conditions, patient care management, and education.</p> | | | 5/24/2012 | |

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| C 200 | <p>Continued From page 9</p> <p>The EDR did not contain documentation of any further blood sugar testing or of confirmation with the lab after determining the glucometer was unable to provide an accurate value.</p> <p>During an interview with the Director of Quality and Risk Management on 4/18/12 at 2:30 PM. She reviewed Patient #18's record and confirmed the lab and glucometer results. The Director of Quality and Risk Management stated there was no protocol for glucose testing, and would follow physician orders for the testing, whether by glucometer or actual lab draws.</p> <p>b. Patient #19 was a 36 year old female who came to the ED on 3/29/12. The time of registration entered into Patient #19 record was 7:17 PM. The triage RN assigned Patient #19 acuity of "Semi-Urgent" at 7:10 PM, and noted "feels shaky -5 hrs. Hx (history) DM BG (blood glucose) 218 today."</p> <p>The EDR for Patient #19 documented the following events:</p> <p>-7:34 vital signs were taken and she was offered orange juice and sugar.</p> <p>-7:40 PM The "PRIMARY ASSESSMENT" was done by the RN.</p> <p>-7:48 PM the RN noted a one-touch (glucometer) reading of 68, which was 14 minutes after the orange juice and sugar was offered.</p> <p>-8:27 PM, the RN documented Patient #19 felt much better, and wanted to go home. Patient #19 signed a LWOT form and left the ED.</p> | C 200 | | | |

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| C 200 | Continued From page 10 The record did not contain documentation that the RN tested Patient #19's blood glucose before offering orange juice and sugar. The RN did not document she had received physician orders for Patient #19 for the glucometer testing or treatment of orange juice and sugar. The record did not contain documentation that the RN had provided patient discharge instructions regarding hypo/hyperglycemia. In an interview on 4/18/12 at 11:45 AM, the ED Manager reviewed Patient #19's record and confirmed the patient left before being seen by the physician. The ED Manager stated the RN should have obtained a physician order before providing orange juice and sugar to the patient. The ED Manager stated there is not a protocol or policy for ED management of diabetic patients. The CAH did not ensure comprehensive monitoring of diabetic patients. The cumulative effect of these negative facility practices impeded the ability of the facility to provide emergency services in a timely fashion and had the potential to result in negative patient outcomes. | C 200 | | |
| C 274 | 485.635(a)(3)(ii) PATIENT CARE POLICIES [The policies include the following:] policies and procedures for emergency medical services This STANDARD is not met as evidenced by: | C 274 | | |

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| C 274 | <p>Continued From page 11</p> <p>Based on review of clinical records and hospital policies and staff interview, it was determined the CAH failed to develop and implement policies and procedures governing emergency services. This resulted in a lack of guidance to 1 of 1 staff RN who was interviewed. The lack of direction prevented staff from following a consistent process for the evaluation and monitoring of ED patients. The findings include:</p> <p>1. The policy "Emergency Department Triage Policy," dated January, 2009, defined triage as "The sorting out and classification of patients or casualties to determine priority of need and prbper place of treatment." The policy stated "Each Emergency Department will determine: 1.2 Who initially assesses the patient. 1.2.1 Where this initial assessment takes place. 1.2.2 Training required of those performing the initial assessment. 1.3 Components of the initial assessment to be performed based upon the patient's chief complaint and/or reason for coming to the ED. 1.3.1 Training required of the staff performing the assessment. 1.4 The minimum criteria that comprises the initial nursing triage/assessment of the patient. 1.4.1 Components of the nursing triage/assessment to be performed based upon the patient's chief complaint and/or reason for coming to the ED. 1.4.2 Training required of the staff performing the assessment." The policy stated the ED would use a 5 level triage classification system including resuscitative, emergent, urgent, semi-urgent, and non-urgent. The policy did not specifically state who could perform a triage assessment or the training required to do so. The policy did not specifically define a minimum triage assessment, for example, whether vital signs were required or</p> | C 274 | <p>Response for C274 contains related elements for triage, patient monitoring between triage and physician assessment, patient care policies/procedures, Emergency Department orders and medical record documentation.</p> <p>To supplement existing Emergency Department Triage Policy previously submitted, a facility level procedure titled: <u>Cassia Regional Medical Center (CRMC) Emergency Department Triage Procedure</u> has been updated and is under review for final approval and implementation. This document outlines the steps that are to be taken by the Emergency Department (ED) staff in triaging a patient in the ED. This document will be reviewed by ED Quality Committee scheduled for May 14th, submitted for review and approval to Medical Executive Committee May 16th and then submitted to the Governing Board for final approval May 23, 2012. A triage workshop is scheduled for the ED staff May 24th for education and final implementation.</p> | | 5/24/2012 |

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| C 274 | <p>Continued From page 12</p> <p>not. The policy did not define where the triage assessment should take place. In addition, the policy did not specify how patients would be monitored after they were triaged and while they were waiting to be examined by a physician.</p> <p>The Director of Quality and Risk Management was interviewed 4/18/12 beginning at 11:05 AM. She stated the hospital did not have specific policies defining the triage process and the monitoring of patients. She stated the hospital had developed specific policies in the past but these policies had been rescinded and replaced by the current policy. She also confirmed a policy regarding the monitoring of patients while waiting for examination had not been developed.</p> <p>2. The RN on duty in the ED was interviewed on 4/18/12 beginning at 8:05 AM She stated she was not aware of policy which defined the hospital's triage process or how patients were to be monitored while they waited to be examined by a physician. She stated she sometimes talked to patients through the window of the reception area and then assigned those patients a triage acuity level. She stated she did not necessarily perform a physical assessment of patients or take their vital signs in order to assign a triage acuity level. She stated she checked on patients in the waiting area who had not been examined by a physician. However, she stated she did not document this monitoring.</p> <p>The hospital did not provide direction to staff regarding the nursing assessment and monitoring of ED patients.</p> | | | C 274 | <p>C274:</p> <p>In reference to the Emergency Department Orders: The form was reviewed with the ED physicians and nursing staff at the ED Department meeting held 4/26/2012. Additional discussion will be held at the ED Quality Committee scheduled May 14th. Education was completed outlining the Emergency Department Orders and how to complete the form. Each order for medications or lab, x-ray or any other treatments ordered for the patient as part of the plan of care must include a time of order before the appropriate staff can carry out the order. Education held with nursing staff regarding a complete medication order and the need to sign, date and time each order as part of the patient care order authentication as outlined in the <u>Patient Care Orders Verification Procedure</u>. New hires to the ED will receive this training as part of the department specific orientation.</p> <p>Following training, from June 1st through August 1, 2012 concurrent review of 100% of ED visits will be conducted by the ED staff members for two months to ensure understanding and compliance with documentation requirements. Medical records of patients seen in the ED each day will be reviewed prior to the end of the shift by the primary care nurse. A review worksheet will be completed to determine compliance with documentation of time physician orders were written as well as the noting of patient care orders by the nursing staff. Compliance with areas of review will be calculated for each ED team member by the department manager and shared during monthly department meetings. Individual counseling will occur as needed. The ED manager or staff designee will perform random record review monthly through end of 2012 to determined continued compliance and then quarterly through 2013 to sustain improvements and then annually thereafter. Information will be reported to staff during team meetings and through monthly Quality Council reports.</p> | | 4/26/2012 |
| C 302 | 485.638(a)(2) RECORDS SYSTEMS | | | C 302 | | | 8/1/2012 and ongoing |

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| C 302 | <p>Continued From page 13</p> <p>The records are legible, complete, accurately documented, readily accessible, and systematically organized.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and policies, the CAH failed to ensure documentation was complete and/or accurate for X of 23 ED patients (#4, #16, #18) whose records were reviewed. This resulted in incomplete or inaccurate medical records. it had the potential to interfere with clarity of information, coordination of care, and accuracy of medication administration. Findings include;</p> <p>Charting was incomplete in the following patient records:</p> <p>POLICY</p> <p>1. Patient #4 was a 31 year old male who presented to the ED on 12/17/12. The Registration form indicated Patient #4 was admitted at 11:27 AM. His triage note was timed 11:25 AM, and stated he took approximately 15-25 pills of Paxil. an antidepressant at 11:00 AM.</p> <p>A form, titled "Emergency Department Orders," dated 12/17/12, contained preprinted laboratory orders, medication orders, treatments, and radiology tests. The form included a column beside the orders for a physician to write the time of the specific order. Patient #4 had labs drawn, as well as an ECG, as indicated by circles around the specific orders, although the time of those orders was not filled in. Medications, however, were noted to have times in the appropriate</p> | C 302 | <p>Response for C302 contains elements for assuring medical records are legible, complete, accurately documented, readily accessible and systematically organized.</p> <p>Appropriate use of order sets and protocols were reviewed with the ED physicians and nursing staff at the ED Department meeting held 4/26/2012. Currently there are no standing order sets approved for use in the ED. All patient care is to be completed via [REDACTED] Clinical Practice Guideline: Basic Cares ED Protocol. Orders for medication, therapy, treatment, diagnostic studies or other treatment modalities outside the Basic Cares ED Protocol requires a physician order. All physician orders must be accompanied by a timed order for nursing to carry out the order.</p> <p>Following training, from June 1st through August 1, 2012 concurrent review of 100% of ED visits will be conducted by the ED staff members for two months to ensure understanding and compliance with documentation requirements. Medical records of patients seen in the ED each day will be reviewed prior to the end of the shift by the primary care nurse. A review worksheet will be completed to determine compliance with medication orders and other treatment modalities will be assessed to ensure that all medications given and treatments ordered are in compliance with the physician's orders as documented in the ED record of care. Compliance with areas of review will be calculated for each ED team member by the department manager and shared during monthly department meetings. Individual counseling will occur as needed. The ED manager or staff designee will perform random record review monthly through end of 2012 to determined continued compliance and then quarterly through 2013 to sustain improvements and then annually thereafter. Information will be reported to staff during team meetings and through monthly Quality Council reports.</p> | 8/1/2012 and ongoing |

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| C 302 | <p>Continued From page 14 columns.</p> <p>In an interview on 4/17/12 at 5:07 PM the ED Manager reviewed Patient #4's record and confirmed the "Emergency Department Orders" sheet was not timed when the specific orders were written. In addition the ED Manager stated there was no notation of orders by the RN noting receipt of the orders.</p> <p>The lack of timing of physician 's orders lacked clarity of the provision of patient care.</p> <p>2. Patient #16 was a 6 year old female who came to the ED on 3/29/12. The time of registration entered into Patient #19's record was 5:30 PM, The triage RN documented Patient #16 had complained of left wrist pain after falling off of a trampoline. Triage acuity for Patient #16 was not documented, and there was no triage time, although the arrival time on the EDR stated 3:30 PM and 6:20 PM.</p> <p>The "PRIMARY ASSESSMENT" by the RN was timed at 6:20 PM, and included a note as follows: "1600 (4:00 PM) - pt arrived @ 1500 (3:00 PM,) LWOT @ 1600- back at 1820 (6:20 PM) to be seen."</p> <p>It was unclear if Patient #16 had been initially triaged at 4:00 PM, or at 6:20 PM. The EDR did not contain further documentation of why Patient #16 left, or if there was an assessment of the patient condition before she left. The LWOT form was not in the patient record as the RN had documented in her note.</p> <p>In an interview on 4/17/12 at 4:30 PM, the</p> | C 302 | | | |

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| C 302 | <p>Continued From page 15</p> <p>Director of Quality and Risk Management reviewed Patient #16's record and confirmed a LWOT form had not been signed, the record did not indicate why the patient had left then returned, and the ARN did not triage the patient.</p> <p>3. Patient #18 was a 46 year old male who was an insulin dependent diabetic. He came to the ED on 3/27/12 at 7:55 AM, and the triage note included: "pt. seen in ER on 3/23/12, Scrotum now black and swollen." A form, titled "EMERGENCY DEPARTMENT RECORD," dated 3/27/12, an RN documented Patient #18 received Tylenol 1000 mg, at 12:25 PM. The "Emergency Department Orders," form completed and signed by the physician did not indicate Tylenol was ordered. In addition, the "Emergency Department Orders," contained orders for laboratory blood tests, a CT scan, and ultrasound, but were not timed by the physician.</p> <p>During an interview on 4/18/12 at 2:30 PM, the Director of Quality and Risk Management reviewed Patient #18's record and confirmed the orders were not timed, as well as the lack of written order for Tylenol.</p> <p>The untimed orders lacked clarity as to when the physician ordered the tests and procedures and when they were completed.</p> <p>*. Patient #7's medical record documented a 31 year old female who presented to the ED on 4/12/12 at 8:53 AM. The EDR stated Patient #7's chief complaint was "migraine." The triage section of the EDR stated "Pt was seen in</p> | C 302 | <p>C302: Documentation of left without treatment (LWOT) and left against medical advice (LAMA) was reviewed with ED staff during department meeting 4/26/2012. The procedure: Emergency Medical Treatment Procedure & Treatment Rejection Policy was reviewed outlining the documentation requirements and definitions of LWOT and LAMA patients. Patients leaving our premises must have the corresponding form filled out fully with times and dates and description of what occurred, and if the patient elects to return to CRMC's ED, the patient will be registered as a new encounter visit. Reasonable efforts will be made to have the patient sign the form; Staff will follow the Emergency Medical Treatment Procedure & Treatment Rejection Policy. LWOT/ LAMA forms that are completed with the appropriate patient identifying information will be included as part of the patient's medical record.</p> <p>Following training, from June 1st through August 1, 2012 The ED Manager and Quality Director will conduct 100% review of all LWOT and LAMA patients each month to ensure appropriate assignment of LWOT/LAMA and completeness of documentation. The ED manager or staff designee will perform 100% LWOT/LAMA record review monthly through end of 2012 to determined continued documentation compliance, and then quarterly through 2013 to sustain improvements and then annually thereafter. Reasons/cause for LWOT/LAMA will be identified for trends and monitored. Information will be reported to staff during team meetings and through monthly Quality Council reports.</p> | <p>4/26/2012</p> <p>8/1/2012 and ongoing</p> | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2012
FORM APPROVED
OMB NO. 0938-0391

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|---|--|--|---|-----------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER(SUPPLIER/CLIA IDENTIFICATION NUMBER: 131326 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 04/19/2012 |
| NAME OF PROVIDER OR SUPPLIER CASSIA REGIONAL MEDICAL CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1501 HILAND AVENUE BURLEY, ID 83318 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| C 302 | <p>Continued From page 16 [physician office] & given Amlodipine [a blood pressure medication] & has been nauseated." The triage section of the EDR also stated her blood pressure was elevated. The "Triage Acuity" section stated Patient #7 was classified as "Semi-urgent." It was not clear how this classification was determined since no assessment or vital signs were documented.</p> <p>Patient #7's EDR contained a section labeled "PRIMARY ASSESSMENT" which documented an assessment by the RN beginning at 10:10 AM. It stated Patient #7 had vomited and her pain level was 7-8 of 10. A check indicated a neurological assessment was within defined limits, or normal. Her blood pressure was 158/126.</p> <p>The EDR documented the physician examined Patient #7 beginning at 10:30 AM on 4/12/12. The "ED Physician/LIP Report," dated 4/12/12 at 12:36 PM, diagnosed Patient #7 with headache and "Hypertension, which could be related to each other." Patient #7 was treated with IV fluids, IV narcotic pain medication, and IV anti-nausea medication.</p> <p>Patient #7 was discharged home at 12:48 PM. Nursing notes stated her pain level had decreased to 2/10. Her blood pressure continued to be very high, however. The last documented blood pressure was dated 4/12/12 at 12:51 PM. It was 172/128.</p> <p>The RN who cared for Patient #7 was interviewed on 4/18/12 beginning at 8:05 AM. She reviewed the EDR. She stated Patient #7 had presented to the ED at 8:53 on 4/12/12. She stated she had</p> | C 302 | <p>The ED staff will be re-educated regarding the Headache ED Chief Complaint during the May 24th workshop. The guidelines indicate assessment, and evaluation communication of findings to the ED physician.</p> <p>The ED staff will be re-educated regarding the Hypertension Newborn Pediatric Adult Problem Clinical Practice Guideline during the May 24th workshop. The guidelines indicate assessment, and evaluation communication of findings to the ED physician</p> | <p>5/24/2012</p> <p>5/24/2012</p> | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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|---|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131326 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 04/19/2012 |
| NAME OF PROVIDER OR SUPPLIER CASSIA REGIONAL MEDICAL CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1501 HILAND AVENUE BURLEY, ID 83318 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X6) COMPLETION DATE |
| C 302 | <p>Continued From page 18 with the ED Manager on 4/18/12 beginning at 11:40 AM. She confirmed the lack of documentation in Patient #22's record.</p> <p>Patient #22's medical record was not complete.</p> <p>*. Patient #23's medical record documented a 58 year old male who presented to the ED on 3/15/12 at 11:18 PM complaining of leg pain. No documentation was present to show Patient #23 was triaged or otherwise assessed by an RN. No examination by a physician was documented. No documentation of any care provided to patient #23 was present. A form, "REJECTION OF TREATMENT/LEAVING AGAINST MEDICAL ADVICE," dated 3/15/12, was signed by Patient #23 and an RN. The time it was signed was not documented. The form stated Patient #23 decided not to wait and went to another emergecny room.</p> <p>The medical record for Patient #23 was reviewed with the ED Manager on 4/18/12 beginning at 11:40 AM. She confirmed the lack of documentation in Patient #23's record.</p> <p>Patient #23's medical record was not complete.</p> | C 302 | | | |

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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May 22, 2012

Rod Barton, Administrator
Cassia Regional Medical Center
1501 Hiland Avenue
Burley, ID 83318

Provider #131326

Dear Mr. Barton:

On **April 19, 2012**, a complaint survey was conducted at Cassia Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005305

Allegation #1: Facility failed to supervise a special needs patient in the Emergency Department, which resulted in broken computer cord which the patient placed around his neck.

Findings #1: An unannounced complaint investigation was made on 4/17/12 and 4/18/12. During the investigation, surveyors reviewed twenty-three records of patients who had been treated in the Emergency Department. Administrative documents were reviewed, including incident reports and documentation of patient complaints and grievances. Surveyors observed care provided to patients in the Emergency Department by nursing and medical staff.

One record reviewed was that of a patient who came to the Emergency Department at 4:51 PM with a complaint of nausea, dizziness and anxiety. The medical record indicated he was placed in an examination room; an RN performed an assessment and took his vital signs at 5:10 PM. The physician's note, dictated at 6:18 PM, indicated the patient had a psychiatric history, and ran out of his anti-psychotic medications two days prior to coming to the Emergency Department. The record documented the patient was given a prescription for anti-anxiety medications by the physician, vital signs were taken at 6:15 PM, and he was discharged at 6:20 PM. There was no documentation in his medical record that indicated the patient had unusual behavior while in the

Rod Barton, Administrator
May 22, 2012
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examination room.

The RN who had worked in the Emergency Department on the day the patient came in was interviewed. She stated the patient was well known to the facility, with frequent visits the Emergency Department. The RN was not able to recall unusual behavior by the patient on that particular visit. The RN stated she would be able to recall if equipment had been tampered with, or broken, and would have documented as such in the form of an incident report.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Facility administered Morphine despite caregiver information that Morphine was not effective for the patient.

Findings #2: One record reviewed was that of a patient who came to the Emergency Department with a complaint of nausea, dizziness and anxiety. The medical record indicated he was evaluated by a physician, and provided with a prescription for anti-anxiety medications. The medical record did not indicate the patient received any type of medication during the ED visit.

The RN who had worked in the Emergency Department on the day the patient came in was interviewed. She reviewed the medical record and confirmed medications had not been administered. She stated medications would only be administered after a physician order.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srm